

Assessment

Family Information:

Assessment date:

Version #:

Is this a two-parent household? Yes ☐ No ☐

Name of Father:

Age:

Client ID.:

Name of Mother:

Age:

Client ID.:

Name of and age children:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

List others in the household and relationship:

- 1.
- 2.
- 3.
- 4.
- 5.

Address:

Notes or side observations:

VIEW ASSESSMENT QUESTIONS

DEPENDENT CARE

1. Do you provide care for another family member who lives in your home? If Yes, please explain.
2. Do you need help finding safe and dependable care so that you can work? If yes please explain.

If yes, refer to available resources in your community

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
*ADULT DEPENDENT CARE	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= No issues 2= Some issues, does not interfere with participation 3= Some issues, may interfere with participation 4= Some issues, limited participation for parent 5= Issues, parent cannot participate			

ADULT GENERAL HEALTH

1. In general would you say your health is:
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

 Comments:
2. Have you had injuries or illnesses that caused permanent changes in your life?
3. Do you or your partner have any medical conditions or disabilities that would make it hard for you to get or keep a job? (for child health issues use child health section)
☐ If no, go to #8,
☐ If yes, Please explain:
4. If yes, are you (or your partner) currently under a doctor's care or receiving treatment for this condition?
5. If yes, do you have documentation from your doctor?
6. If yes to #2-5, Given the health issues you (or your partner) face, what type of work do you feel you can do?

7. Do you use any medication regularly that may prevent you from working or make it hard for you to work (side effects)?
8. Do you feel you have *any* (health related or not) disabilities that makes it hard or impossible for you to work?

If any issues exist, consider what equipment/accommodations might be needed to find or keep a job?

Is child care needed to go to the doctor or receive treatment

9. Is there anything about your medical history that may affect your participation?

Topic	Baseline Scale	Score	Recommend Resolution	Strengths
*ADULT GENERAL HEALTH	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= Physical health appears good 2= Some physical health issues, does not interfere with participation 3= Some issues, may interfere with participation (e.g. chronic bad back, migraines) 4= Some issues, limited participation 5= Significant Issues, cannot participate			

ADULT MENTAL HEALTH

NOTE: Accurate diagnosis of psychological disorders requires a physical examination by a physician who can determine if an evaluation by a mental health professional (certified mental health counselor, psychologist, or psychiatrist) is appropriate and needed.

A score of 6 or more in either of the following two screens may indicated the need for further evaluation by the participant's primary care provider who will make a determination if further mental health evaluations are appropriate.

1. Depression: Never or Hardly Ever = 0 Sometimes = 1 Most of the time = 2

In the past month how often have you felt?

Sad, Blue, "Down in the Dumps?"

Tired, little energy, unable to concentrate?

Sleeping too little/too much?

Eating too little/too much?

Not enjoying activities that you used to enjoy?

Everything you do takes effort?

TOTAL:

2. Has anything happened within in the last few weeks that has made you feel depressed; such as divorce or loss of a loved one?

3. Anxiety Disorders: Never or Hardly Ever = 0 Sometimes = 1 Most of the time = 2

Worry excessively?

Shortness of breath heart palpitations, shaking?

Feel like you are loosing control of yourself?

Avoiding social situations/fear of others?

Anxiety/ Panic attacks?

Isolating yourself/fear of leaving the safety of your home?

TOTAL:

4. Is there anything that you are struggling with now that make it difficult for you to find or keep a job?

☐ Stress/trauma ☐ Physical/Emotional/Sexual Abuse ☐ Anger/Frustration ☐ Suicidal thoughts ☐ Other

5. Have any of the above issues affected your normal day-to-day activities or relationships with others? If so, how?

6. Is there anything else you would like to talk about that affects your ability to find or keep a job?

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
*ADULT MENTAL HEALTH	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= No mental health symptoms identified 2= Some mental health issues, does not interfere with participation 3= Some mental health issues, may interfere with participation 4= Some mental health issues, limited participation 5= Significant mental health Issues, cannot participate			

CHILD CARE QUESTIONS

Child #1 (Name):

Child #2 (Name):

Child #3 (Name):

Child #4 (Name):

1. If you were to get a job today, would you need help finding child care that is safe and dependable?

If no, document current plan and ask if they also have a back up plan. (Discuss and document what the back up plan is). Go to question #7

If yes, what help do you need in obtaining child care(i.e. money, locating a child car provider who can meet you child's needs, etc.). (referral to WCCC)

2. Do you know what types of questions to ask and what to look for when looking for child care? (If no, go over child care brochure (DSHS 14-XXX describing important things to look for)
3. When looking for care for your child, what is most important for you and your child? (i.e. Cultural sensitivity, location, hours of operation, family home vs. child care center, staff that can meet your child's special needs, etc.)
4. Does you child have any special child care needs?

(If yes, contact the Child Care Resource and Referral who can help the parent find child care providers for children with special needs and consider referring to the public health nurse for special needs child care.)

5. Are you aware of the Child Care Resources and Referral Network and how they can help you find child care in your community?

☐ Yes ☐ No (if no, refer to Child Care Resource and Referral)

6. Have child care issues ever kept you from getting or keeping a job?

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
CHILD CARE	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= client has cc provider and backup plan 2= Client has cc, but no back up plan 3= Some issues, may interfere with participation (i.e. child care needs to be located) 4= Some issues, limited participation for parent (i.e. child care is limited in some way) 5= Issues, parent cannot participate (i.e. type of child care needed not available)			

CHILD WELFARE

Child #1 (Name):

Child #2 (Name):

Child #3 (Name):

Child #4 (Name):

1. How would you describe your relationship with your child (ren) (i.e. do you get along well with your kids, are there issues that make it hard to get along or communicate, do you feel your child responds well to your guidance and parenting style?
2. How would you describe the relationship between the child(ren) and his/her other parent? (same prompts as above)
3. If you have more than one child, how would you describe the relationship between your children? (do they get along, are there issues that you consider out of the ordinary for siblings or that cause problems or upset in your family?).
4. If you have a significant other, other than the other parent of the child(ren), how would you describe that relationship with the child(ren)?
5. How would you describe the relationship between your child(ren) and other relatives in your family? (Do they visit each other often, do they get along with or are they close to other relatives, are there other adult relatives your child trusts and can count on in an emergency?)
6. What does your child(ren) like to do for fun?
7. Do you have any concerns about school attendance with your child(ren)?
8. When your child misses school what is usually the reason (illness, skipping school, suspended, etc.)?
9. How do you feel your child is performing academically in school?
10. How do you feel your child is relating with other children/peers?
11. How do you feel your child is relating to adults and teachers?
12. Do you have any concerns about the type of friends your child chooses? (are they usually the same age? Are they older, younger?)
13. Has your child been involved in any way with the legal system?

14. Are you currently involved with any other agencies regarding child issues?

If any of the above responses indicate a behavioral, mental, or physical health concern consider referral to the public health nurse for evaluation.

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
*CHILD WELFARE (i.e. school performance, trouble in legal system, family interactions, child abuse and neglect issue)	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= No issues 2= Some issues, does not interfere with parent's participation, supports may be needed 3= Some issues, support need to be put in place to support parent's participation 4= Some issues, limited participation for parent, supports need to be put in place 5= Issues, parent cannot participate and significant support and resources are needed			

CHILD GENERAL HEALTH

Child #1 (Name):

Child #2 (Name):

Child #3 (Name):

Child #4 (Name):

- Overall, how would you say your child(ren)'s health is?
- Is there one health provider you think of as your child(ren)'s personal doctor or nurse?
- Has your child(ren) received regular check ups when he/she is not sick?
- Do you know if your child(ren) up to date with his/her immunizations? (if not sure, refer or assist them in finding out)
- Do you think your child(ren) gets sick more often than other children do?
If yes, explain:
- If yes, has this affected your ability to get or keep a job?
- Has your child(ren) missed a lot of school or daycare due to health problems?

8. If yes, has it caused any problems at school or with the daycare?

9. Do you have any concerns about your child(ren)'s health right now? If yes, explain:

10. Is there anything else you think is important to discuss?

If yes to #5- #9, assist in connecting with Primary health Care provider and refer to public health nurse for evaluation.

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
*GENERAL CHILD HEALTH	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= Child health is good 2= Some child health issues, does not interfere with parent's participation but parent needs some supports in place. 3= Some child health issues, may interfere with parent's participation, supports need to be in place. Refer to primary care provider and PHN 4= Child health issues, supports must be in place, limited participation for parent. Refer to primary care provider and PHN 5= Child health Issues, child's health problems are significant and parent cannot participate. Refer to primary care provider and PHN			

CHILD HEALTH – CHILDREN WITH SPECIAL NEEDS

Child #1 (Name):

Child #2 (Name):

Child #3 (Name):

Child #4 (Name):

Screen for Special Needs:

1. Do you have a child who uses medicine prescribed by a doctor (other than vitamins)? If so, what condition is the medication used for?

2. Do you have a child who is limited in his/her ability to do things most children of the same age do? If yes, please describe:

3. Does your child need or use more medical care, mental health or special educational services than usual for most children of the same age?

4. Does your child have any kind of emotional, developmental or behavioral problems for which he/she gets treatment or counseling?
medical diagnosis or documentation?

If yes, is there a

If yes, how does it impact ability to participate?

If yes to any —refer to Public Health Nurse (PHN) for special needs evaluation.

5. Have you had difficulty locating child care due to your child's health needs?

If yes, refer for PHN evaluation.

Topic	Baseline Scale	Score	Recommend Resolution	Strengths
*CHILDREN WITH SPECIAL NEEDS (physical, mental, behavioral)	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= Child has no special needs 2= Some issues, child has mild or intermittent issues that will likely not affect the parent's ability to participate 3= Some issues, may interfere with parent's participation, evaluation by PHN needed 4= Some potentially significant issues, limited participation for parent, evaluation by PHN needed. 5= Issues, Child has significant issues and parent cannot participate, evaluation by PHN needed			

EMPLOYMENT

1. Are you currently working? (If NO, go to question #3)

2. If yes, are you employed 20 hours or more a week?

*If no, do you need help getting more hours or finding a better job?

If yes, referrals made? Then go to question #6

3. Have you ever been employed?

If Yes: When did you last work?

What type of job was it?

Is that the type of work you normally do?

How long were you with your last employer?

What was the reason for leaving?

What is the longest amount of time have you worked in one job?

When was it?

What type of job was it?

What was your reason for leaving?

4. Is there anything that prevents you from getting or keeping a job now?
5. What do you feel you need to get or keep a job?
(Prompts: family issues, job readiness skills, e.g., get along with co-workers, Read and follow instructions, basic computer skills, etc).
6. Are there any areas you feel you need extra help with so you can get or keep a job working 20 hours or more a week?
7. What do you feel are your strengths in getting/keeping a job (i.e. always on time, willingness to learn, etc.)
8. What are your career goals or what type of job would you like to be doing in 5 years?
 - (a) What type of training (if any) would you need in order to meet those goals?
 - (b) What is your plan to reach your career goal?
9. Is there any thing else about employment you think is important to talk about?

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
EMPLOYMENT	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= Employed and participating full-time 2= Employed part-time-no issues, can participate full-time 3= Employed part-time- employment related issues may interfere with participation 4= Not employed - some employment related issues limit participation 5= Not employed - client unable to work at this time due to unresolved issues			

FAMILY PLANNING

1. What size of family are you planning to have?
2. How far apart do you plan on spacing you children?
3. Are you currently using birth control?
If yes, what method?
If no: refer to family planning worker or Nurse as appropriate.
4. If yes to #3, are you satisfied with this method? If no, refer to family planning worker or Nurse as appropriate.

5. Are you aware of the different methods of birth control available with your medical coupon?
6. Are you aware that your medical coupon will pay for your annual exam?
7. Would you like information on Emergency Contraception pills or "morning after" treatment that can be taken within 3 days of unprotected sex?
8. Did you know that we have a family planning worker/nurse in our office to privately discuss family planning with you or your teenage child(ren)?
you like to meet with them or have them contact you? Would
9. Anything else you would like to discuss? (Document all referral made)

FAMILY SUPPORT

1. How would you describe your relationship and interactions with extended family? (i.e. supportive, close, not in communication, live too far away)
2. What types of things do you like to do in your spare time?
3. What types of social activities are you involved in (i.e. church, boy/girl scouts, volunteer activities, school activities, hobbies, other organizations).
4. If you had a personal crisis, whom would you call or turn to first?
5. Do you feel like you have the support of your family and/or friends if you go to work?

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
*FAMILY SUPPORT SYSTEMS (extended family, church, neighbors, social networks, Isolation issues, other)	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= Lots of family and community support 2= Support from either family or community 3= Some support from either family or community 4= No support from either family or community 5= No support at all			

FAMILY VIOLENCE

1. Do you need immediate help to escape from someone who is hurting you or your children?
2. Do you need to keep your address secret? (refer for address confidentiality program).
3. Are you, or have you been mentally, physically or emotionally hurt by a family member, partner or ex-partner?
4. Is a family member or partner controlling you?
5. Are you staying or have you recently stayed in a domestic violence shelter?

6. Are you afraid to leave your children at school or in daycare because of your partner or other parent?

7. Have you ever obtained a protection order?

8. Are you or anyone else afraid for your child(ren's) and your safety right now?

☐ Yes ☐ No

If yes, explain:

9. Are you or have you been afraid of your current or ex-partner or other household member?

☐ Yes ☐ No

Comments:

10. Have you or has anyone else ever called the police because of a family argument?

☐ Yes ☐ No

If yes, please explain:

11. Who controls the money in your household? Do you have access to money that you earn or receive?

☐ Yes ☐ No

Comments:

12. How would your partner respond if you became more financially and socially independent?

13. Have you ever asked for help from anyone such as relatives, church, or a domestic violence agency for family violence?

☐ Yes ☐ No

If yes:

When:

What was the outcome?

14. If yes to any of the above, what are you doing to keep your children and yourself safe and resolve any past domestic violence issues?

15. The state has an Address Confidentiality Program that may help protect you and your family. Would you like to know more about it?

☐ Yes ☐ No

16. Are we (in WorkFirst) asking you to do something that makes you feel unsafe?

☐ Yes ☐ No

17. If yes to any of the above and you are unable to participate in WF activities because of family Violence issues, are you willing and able to work on resolving your domestic violence issues?

☐ Yes ☐ No

18. Client wants to participate in WF activity/job search

☐ with domestic violence services

☐ without domestic violence service

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
FAMILY VIOLENCE	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= No issues 2= Some or past issues, does not interfere with participation 3= Some issues, may interfere with participation 4= Some issues, limited participation for parent 5= Issues, cannot participate			

HOUSING

1. What is your current housing situation (e.g. stable, facing eviction, renting, homeless, moving from place to place)?

(If housing is an issue discuss support services and community housing resources)

2. Has your housing situation prevented or kept you from finding or keeping a job?

3. Are you currently working with any other agency on a housing issue?

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
HOUSING	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= Has stable housing (can participate) 2= Moderately stable, can participate, (e.g. client is looking for other housing) 3= Some issues, may limit participation, (e.g. rent may become an issue due to income ratio) 4= Unstable. participation is limited until resolution can be found (e.g. living with friends/relatives, or otherwise unstable) 5= Critically unstable, issues must be resolved prior to participation.			

LEARNING NEEDS SCREENING

YES

1. ☐ Did you have any problems learning in middle school/junior high?
2. ☐ Do you have difficulty working from a test booklet to an answer sheet?
3. ☐ Do you have difficulty or experience problems working with numbers in a column?
4. ☐ Do you have trouble judging distances?
5. ☐ Do any family members have learning problems?

1X = = Count the number of yes's and multiply by 1.

6. ☐ Did you have any problems learning in elementary school?
7. ☐ Do you have difficulty or experience problems mixing mathematical signs (+/x)?

2X = = Count the number of yes's and multiply by 2.

8. ☐ Do you have difficulty or experience problems filling out forms?
9. ☐ Do you experience difficulty memorizing numbers?
10. ☐ Do you have difficulty remembering how to spell simple words you know?

3X = = Count the number of yes's and multiply by 3.

11. ☐ Do you have difficulty or experience problems taking notes?
12. ☐ Do you have difficulty or experience problems adding and subtracting small numbers in your head?
13. ☐ Were you ever in a special program or given extra help in school?

4X = = Count the number of yes's and multiply by 4.

Total: If 12 or more, refer to Learning Disabilities Association or the Community College for further assistance and evaluation.

Topic	Baseline Scale	Score	Recommend Resolution	Strengths
LEARNING NEEDS	<p>N/A 1 2 3 4 5 unknown</p> <p>N/A= Not applicable or not assessed 1= No identified issues with learning disabilities 2= Minor issues (i.e. marked yes to family member w/LD or trouble judging distance but does not affect participation. 3= Issues with learning disabilities, score was less than 12, (may interfere with participation) 4= Issues with learning disabilities, score of 12 or more (limited participation) 5= Issues with learning disabilities, score of 12 or more (unable to participate)</p>			

LEGAL ISSUES

1. **Citizenship:** Did you know, if you are not a U.S. Citizen we can provide you with information about how to apply? Are you interested in this information? ☐
Yes ☐ No
(Social Worker can refer to Refugee Worker or the Northwest Justice Website to obtain information and resources)
2. Do you or any family members have any of the following legal issues that may affect your participation? (who, when, what (explanation))
- ☐ Valid driver's license?
(If suspended, refer for licensing services)
(If DUI, consider substance abuse questions)
- ☐ Unpaid traffic tickets?
(If yes, when and what for and how it will affect your participation)
(If yes, refer for Advocacy services if appropriate)
- ☐ Alcohol-related offenses?
(If yes, consider substance abuse screen)
- ☐ Drug-related offenses? (f yes, consider substance abuse screen)
- ☐ CPS involvement with your family?
If yes, please explain how it may affect your participation:
- ☐ Custody issues?

If yes, describe custody situation and how it may affect your participation:
- ☐ Facing an eviction?
If yes, is it currently impacting your ability to find safe or affordable housing? Is it impacting ability to get or keep a job?
(Refer to housing assessment)
- ☐ Bankruptcy or poor credit issues?
If yes, is this impacting your ability to find or keep a job?
- ☐ Upcoming court dates?
If yes, how will it affect your participation?
What are the possible outcomes? (i.e. fines, incarceration)
- ☐ Currently on probation or parole?
If yes, name and phone # of Parole Officer – how long? – restrictions?
- ☐ Any convictions that may affect your ability to work?
- ☐ Is there anything else regarding legal issues that you think may affect your ability to participate?

3. Are you currently working with any other agencies regarding one or more of the issues above?

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
LEGAL ISSUES	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= No issues 2= Some or past issues, does not interfere with participation 3= Some issues, may interfere with participation 4= Some issues, limited participation for parent 5= Issues, cannot participate until addressed or resolved			

LITERACY

1. Do you have your high school diploma or GED certificate? (if no, go to question #3)

☐ Yes ☐ No Comments

2. If Yes, Do you have additional schooling or training (college degree, vocational training)?
(go to question # 5 if appropriate)

3. If NO, what was the last grade you completed in school?

4. What help do you need to obtain your high school diploma or GED?

5. Do you have problems reading or writing?

6. Do you have difficulty speaking, reading and/or writing English? (if yes, refer to LEP pathway)

(check LEP, NSA accommodation plan)

6. Are you currently involved with any Literacy programs?

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
*LITERACY / LEP	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= Has HS diploma or GED, no identified issues 2= No identified issues with literacy, no HS or GED (can participate) 3= Issues with literacy (may interfere with participation) 4= Issues with literacy, (limited participation) 5= Issues with literacy, (unable to participate until resolved)			

OTHER AGENCIES

1. *Are there any other agencies you are working with?*
☐ Child Protective Services (CPS)
☐ Child Welfare Services (CWS)
☐ Family Reconciliation Services (FRS)
☐ Division of Vocational Rehabilitation (DVR)
☐ Division of Developmental Disabilities (DDD)
☐ Division of Alcohol and Substance Abuse (DASA)
☐ Head Start or Early Head Start
☐ Early Childhood Education and Assistance Program (ECEAP)
☐ Community College
☐ Health Dept.
☐ First Steps
☐ Private Industry Council / Welfare to Work (WTW)
☐ Tribal
☐ Other

2. Are there any required community services you are working with? (Schools, libraries, shelters, food banks, churches)

 Name and phone # of contact – when, where – how many hrs

3. If yes to any of the above, do you have an action plan or an activity with that agency that needs to be considered when building an IRP? If yes, please explain:

4. If yes to any of the above, May I contact your worker to coordinate services?

5. Is there anything else you think is important to talk about?

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
OTHER AGENCY INVOLVEMENT	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= No issues 2= Some or past involvement, does not interfere with participation 3= Some involvement, may interfere with participation 4= heavy involvement, limited participation for parent 5= Issues and heavy involvement, cannot participate until stabilized			

PREGNANCY

1. Are you currently pregnant? ☐ Yes ☐ No (If no, skip to next section.)
2. If yes, has your pregnancy been confirmed? ☐ Yes ☐ No

If yes, Due date

3. Date of last visit
Date of next visit
Doctor or Health Care Provider
Name of Healthy Options Plan

4. What are your plans for this pregnancy?
☐ Parenting
☐ Adoption
☐ Termination (if yes, ask #4, then skip to #14)
Referrals Made:

5. Are you aware that you will receive family planning services after your pregnancy?

6. How is your pregnancy going?

Referrals Made:

Medical factors and history:

Number of previous pregnancies ; Births ; Still Births ; Miscarriages ;

- ☐ tobacco
- ☐ hypertension
- ☐ prescriptions
- ☐ HIV/AIDS
- ☐ Chronic illness
- ☐ Medications
- ☐ Premature labor/births
- ☐ Diabetes
- ☐ Mental illness
- ☐ Alcohol/substance abuse
- ☐ Physical disability
- ☐ Other

7. Did you plan this pregnancy?

What were your feelings about this pregnancy when you first learned you were pregnant?

8. How do you feel about the pregnancy now?

9. How does the father of the baby feel about this pregnancy? (other possible questions: Who is father of your baby? How old is he? Is he going to be involved and supportive)

10. Are you aware of the services provided by the Division of Child Support? (Paternity Affidavit, Good Cause, Paternity Establishment, Parenting Plan)

11. Were you using birth control at the time of conception?

If yes, what type?

If no, are you aware of the types of birth control available?

12. Have you thought about what forms of birth control you want to use at the end of this pregnancy:

i.e.

- ☐ birth control pills
- ☐ Norplant
- ☐ Vasectomy
- ☐ Depo Shot
- ☐ Diaphragm
- ☐ Abstinence
- ☐ Condoms (male or female)
- ☐ Cervical Cap
- ☐ Rhythm Method
- ☐ IUD
- ☐ Tubal Ligation
- ☐ ECP (Emergency Contraception Pill)
- ☐ Spermicides
- ☐ Foam
- ☐ Film
- ☐ Gel
- ☐ Suppositories
- ☐ Other

13. Do you have any questions, concerns or issues about pregnancy options, family planning, birth control, or childbirth classes?

14. Are you working with any other programs, such as First Steps, W.I.C., parenting classes, C.P.S.?

15. Maternity Case Management Eligibility (Risk factors indicating eligibility for MCM):

A. Experience at least one of the following:

- ☐ Age 17 or younger
- ☐ Alcohol and/or drug use by the individual and/or the presence of alcohol/drugs in the environment OR

B. Demonstrate an inability to access necessary resources and/or services, and who experience at least three of the following:

- ☐ Homelessness/Staying with friends/relatives on a short term basis or in a shelter
- ☐ Current or recent violence (i.e physical or sexual)
- ☐ Lack of support system, uninvolved partner
- ☐ Medical factors related to pregnancy outcome (i.e. diabetes, hypertension, chronic illness, etc)
- ☐ Two or more children age 4 or under in the home
- ☐ Education at eighth grade level or less
- ☐ Physical disability

- ☐ Mental impairment / depression
- ☐ Refugee status (does not include undocumented aliens)
- ☐ Ages 18 or 19
- ☐ Limited English proficiency
- ☐ Late entry into prenatal care

Topic	Baseline Scale	Score	Recommend Resolution	Strengths
PREGNANCY	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= No issues 2= Some issues, does not interfere with participation 3= Some issues, may interfere with participation 4= Some issues, limited participation for parent 5= Issues, parent cannot participate			

ALCOHOL and SUBSTANCE ABUSE

Currently or in the past year:

1. Have you lost a job or failed to complete school or training program due to the use of alcohol or drugs?
2. Do you feel or have you felt you should cut down on your drinking or drug use (if yes, what has been the drug of choice)?
3. Do people or have people annoyed you by criticizing your drinking or drug use?
4. Do you or have you felt bad or guilty about your drinking or drug use?
5. Do your partner or family member have/had any issues with alcohol or substance abuse? If yes, explain:
If no to #1-5, go to question #10.
6. If yes to any of the above, tell me more about how alcohol or drug use does affect or has affected you and your family?
i.e:
 difficulty getting a job or looking for a job
 - difficulty at work or school
 - problems you are having at home
 - concerns expressed by others, etc.
 - caused other issues such as:

- ☐ Missed work
- ☐ Late for work
- ☐ Drunk at work
- ☐ Breaking the law

- ☐ Time in jail
- ☐ Traffic fines
- ☐ Loss of driver's license, professional license, insurance, etc.
- ☐ Loss of housing
- ☐ Family rift/violent or irrational behavior

if client indicates an issue, ask: What do you think would make a difference?

7. Have you ever sought help or thought of seeking help for this?

8. Current or previous treatment?
If yes, what was the outcome?

9. How can DSHS help you?

(Review of resources: onsite and offsite resources, what DSHS can and cannot pay for, how treatment fits in with WorkFirst and participation, etc.)

10. If there is anything we haven't discussed about this issue you feel is important?

Topic	Baseline Scale	Score	Recommend Resolution	Strengths
ALCOHOL AND SUBSTANCE ABUSE	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= No issues 2= Some or past issues, does not interfere with participation 3= Some issues, may interfere with participation 4= Some issues, limited participation for parent 5= Issues, cannot participate until addressed or resolved			

TRANSPORTATION

1. What type of transportation do you use?

2. Is this how you normally get around – (child care, doctor appointments, shopping, appointments, interviews)

– If no, how do you normally get around?

3. Is your transportation reliable?

(If no, discuss support services available)

Other optional questions if client uses car:

Do you own the car?

Is it running and reliable? If no, is it fixable?

Do you have a driver's license?

Is your car registered?

Do you have auto insurance?

If there are small children in your care, do you have child car seats?

<u>Topic</u>	<u>Baseline Scale</u>	<u>Score</u>	<u>Recommend Resolution</u>	<u>Strengths</u>
TRANSPORT- ATION	N/A 1 2 3 4 5 unknown N/A= Not applicable or not assessed 1= Has reliable transportation and back up 2= Has transportation but needs back-up plan 2= Some issues, does not interfere with participation 3= Some issues, may interfere with participation 4= Some issues, limited participation due to lack of transportation 5= Issues, cannot participate until issues are resolved			

SCORE DEFINITION AND ACTION REQUIRED-

The following demonstrates how the score is interpreted in relation to a client's participation and the action taken by the Social Worker.

SCORE	DEFINITION	ACTION
1	No Issues	No action needed
2	Client has issues, but doesn't interfere with participation.	Address issues (if possible) notify case manager
3	Client has issues, may limit participation	Identify resources to address issue, and coordinate with CM for participation plan
4	Client has issues, participation is limited	Work with client to resolve issues and gain full-time participation
5	Critical issues, must be resolved or addressed prior to participation	Intensive services to address issues immediately

ASSESSMENT BASELINE SCORE AND GOAL REPORT

The assessment scale in the chart below will be at the end of the assessment. This "result sheet" will be auto-filled from the information input in each assessment section.

Topic	Baseline Score	Resolution/ recommendations	Family Strengths	Three Month Goal Score	Three Month Actual Score	Six Month Goal Score	Six Month Actual Score	Nine Month Goal Score	Nine Month Actual Score	Twelve Month Goal Score	Twelve Month Actual Score
*LITERACY / LEP											
LEARNING NEEDS											
EMPLOYMENT											
TRANSPORATION											

<u>Topic</u>	<u>Baseline Score</u>	<u>Resolution/ recommendations</u>	<u>Family Strengths</u>	Three Month Goal Score	Three Month Actual Score	Six Month Goal Score	Six Month Actual Score	Nine Month Goal Score	Nine Month Actual Score	Twelve Month Goal Score	Twelve Month Actual Score
HOUSING											
ADULT GENERAL HEALTH											
ADULT MENTAL HEALTH											
CHILDREN GENERAL HEALTH											
CHILDREN W/ SPECIAL NEEDS											
CHILD WELFARE											
CHILD CARE											
ADULT DEPENDENT CARE											
FAMILY VIOLENCE											
ALCOHOL AND SUBSTANCE ABUSE											
FAMILY PLANNING											
PREGNANCY											

<u>Topic</u>	<u>Baseline Score</u>	<u>Resolution/ recommendations</u>	<u>Family Strengths</u>	Three Month Goal Score	Three Month Actual Score	Six Month Goal Score	Six Month Actual Score	Nine Month Goal Score	Nine Month Actual Score	Twelve Month Goal Score	Twelve Month Actual Score
LEGAL ISSUES											
OTHER AGENCY INVOLVEMENT											
FAMILY SUPPORT SYSTEMS											

Signatures: 3 month SW

Contractor

CM

Date:

6 month SW

Contractor

CM

Date:

9 month SW

Contractor

CM

Date:

12 month SW

Contractor

CM

Date:

Summary of Action/Narrative 3 months:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

General Comments:

Signatures: 3 month SW	Contractor	CM	Date
Changes: SW	Contractor	CM	Date

Summary of Action/Narrative 6 months:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

General Comments:

Signatures:	6 month SW	Contractor	CM	Date
Changes	SW	Contractor	CM	Date

Summary of Action/Narrative 9 months:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

Topic:
Outcomes/Goals:

General Comments:

Signatures:	9 month SW	Contractor	CM	Date
Changes	SW	Contractor	CM	Date

Summary of Action/Narrative 12 months:

Topic:

Outcomes/Goals:

Topic:

Outcomes/Goals:

Topic:

Outcomes/Goals:

Topic:

Outcomes/Goals:

Topic:

Outcomes/Goals:

Topic:

Outcomes/Goals:

General Comments:

Signatures: 12 month SW

Contractor

CM

Date

Changes

SW

Contractor

CM

Date